Summary of Comments:

Proposed Regulations concerning "Hospice Facilities"

Statement of Purpose Includes: (A) The purpose of this regulation is to repeal section 19-13D-4b and create regulations governing inpatient Hospice facilities pursuant to section 19a-122b of the Connecticut General Statutes; (B) This regulation deletes the language in the current hospice regulations and makes updates to the hospice regulations to make them consistent with federal guidelines and current healthcare delivery standards. (C) This regulation will delete section 19-13-D4b and create sections 19a-122b-1 through 19a-122b-14.

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NUMBER OF COMMENTORS	COMMENT	RESPONSE
5	Repeal of 19-13D-4b and implementation of 19a-122b-1-14 will impact current hospice licenses	No change- There will be a seamless transition of licensure from one section of public health code requirements to the other. Section 19 of the CT General Statues has been repealed and transferred to section 19a. Therefore, the cite for regulations is also changing.
2	Proposed regulations include an "immediate repeal" provision that eliminates immediately the license held by the Hospice's specialty hospital.	No Change- Though one section of regulations will be repealed, continuous licensing for in-patient hospice services will be provided through the new section of the regulations. Section 19 of the CT General Statues has been repealed and transferred to section 19a. Therefore, the cite for

		regulations is also changing. There will be a seamless transition from one license to the other license with no lapse in the services provided.
1	Proposed regulations do not mention the requirement that there will be well-defined written policies clarifying the delivery of inpatient, outpatient, and hospice based home care services.	No change-This comment is address in Section **19a-495-6c** which outlines the responsibilities of the Governing Authority and mandates the licensee, governing authority and administrator to have joint authority and responsibility for the hospice including adopting bylaws or rules that are periodically reviewed. The bylaws or rules must adhere to the criteria listed in this section.
1	The proposed regulations will violate the patient rights and do not protect the rights of patients and families	No change - Patient Rights are addressed in Section **19a-495-6h** Patient Rights and Hospice Responsibilities which requires the Hospice to have a written bill of rights and responsibilities governing services, which shall be available and explained to each patient or representative at the time of the admission. The facility must document in the patient's clinical record that it provided the patient or representative with information regarding the bill of rights. In addition, section **19a-495-6c** (b)(12) mandates the Governing Authority to be responsible for "assuring the protection of patient's rights." In addition, section **19a-495-6g** (a)(3)(B) mandates training for all personnel regarding patient rights and confidentiality.
4	The proposed regulations will lower the standard of capability and performance required for inpatient hospice care	This comment was addressed by revising section (a) of **19a-495-6f** Hospice Facility Services to include the following: (a) The hospice facility shall provide staff in sufficient numbers and services of sufficient duration to meet the physical, psychosocial and spiritual needs of patients and their families. The hospice facility is responsible for ensuring that staffing for all services reflect its volume of patients, their acuity, and the level of intensity of services needed to ensure that the plan of care outcomes are achieved and negative outcomes are avoided.
18	Sections 19a-122b-1 through 19a-122b-14, sufficient staffing ratio is not expressed in the regulations.	No change -The proposed regulations are outcome based. They require that the hospice staffing must meet the needs of the patients. The structural requirement in current regulations for staffing ratios is not flexible, nor responsive to the changing acuity of the patients. It is conceivable that staffing will be better than 1 to 6 under the new regulations. (see also previous response)

1	Infection Control: Proposed regulation does not address the component of infection control.	No changes made, Infection Control is addressed throughout the proposed Hospice regulations sections. For example: Section **19a-495-6g** In-service Training and Education: (a) (3) Annual training for all personnel in: (A) prevention and control of infection. Section**19a-495-6i** Quality Assessment and Performance Improvement (b) (3) subparagraph (E) states: (E) the prevention, surveillance and control of health care associated infections and communicable diseases. Section **19a-495-6i** Quality Assessment and Performance Improvement (b)(4) requires a method and mechanism for identifying and reporting the following: (A) infectious and communicable disease occurrences among patients and personnel: (B) Health care associated infections and a plan for the implementation of actions that are expected to result in improvement and disease prevention. Section **19a-495-6m** Physical plant includes subsection (k) service area requirements, which mandates the hospice to have hand washing facilities conveniently located to each nurse's station and drug distribution station.
9	Ability to immediately deal with changing symptoms, i.e. onsite physician.	There are several sections of the regulation that mandates physician services be available to meet all patient needs. Section **19a-495-6d** Administration (c) mandates the licensee to have a medical director who is a licensed physician with experience and training in hospice care. It also mandates the medical director to have a back-up person when they are not available. Section **19a-495-6f Hospice Facility Services** (b) (2) Attending practitioner services shall be provided by a currently licensed physician or advanced practice registered nurse to meet the medical needs of patients for the management of the terminal illness and related conditions, through palliative and supportive care. Attending practitioner services shall be provided in accordance with hospice policies in a manner consistent with accepted standards of practice and applicable law.

		In addition to palliation and management of terminal illness and related conditions, staff physician(s) and advanced registered nurse practitioner(s) of the hospice including the physician member(s) and the advanced registered nurse practitioner member(s) of the interdisciplinary group shall also meet the medical needs of the patients to the extent that these needs are not met by the attending practitioner.
7	Concerns regarding Medication Administration by Nurse Aides instead of RNs	No changes made, Section **19a-495-6f** Hospice services (b) (7) (F) addresses this: (F) Assisting with the patient's self-administration of medications by: (i) Reminding a patient to self-administer the medication; (ii) Verifying that a patient has self-administered their medications; or (iii) Opening bottles, bubble packs or other forms of packaging if the client is not capable of performing this function. This allows nursing assistants only to provide assistance with medications that are ordinarily self-administered. The purpose of self-administration of medications by patients is to promote independence, dignity and self-care. The RN must make the determination if a patient is capable of self-administration of medications. No judgment is allowed by the nurse aides. The purpose of this section is to allow nursing assistants to help patients who have been assessed to self-administer their medications, in the form of opening bottles or providing other physical assistance. Section **19a-495-6k** Drugs and Biologicals (c) mandates the licensee to have a written policy in place for the accurate dispensing of the medications, completing a record of medications dispensed and ensuring medications are only administered to patients by a currently licensed nurse, physician's assistant, or a licensed independent professional.
		Preplanning the hospice admission allows the necessary medications to be available for the patients as needed. Pharmacy services are available around the clock and medications can be delivered 24 hours a day to the

12	Concerns regarding the lack of an on-site pharmacist/Pharmacy supply.	patients. Point of care Medication Dispensing devices (e.g. Pyxis) are also available to deliver medications as needed. In addition, a locked box may stock commonly needed medications. There are several sections of the regulations that address this comment as follows: **19a-495-6f** Hospice facility Services (b) (9) mandates the facility to receive pharmacy services under the direction of a currently licensed pharmacist who is an employee of or has written agreement with the hospice. Section 19a-495-6k Drugs and Biologicals (c) mandates the licensee to obtain drugs and biologicals from licensed community or institutional pharmacies or establish its own institutional pharmacy. To address this further, Section 19a-495-6k (a) will be revised to mandate drugs and biological be available to the patient on a 24 hour basis. This section will read as follows: (a) The interdisciplinary team shall confer with a currently licensed pharmacist or independent practitioner with education and training in drug management, who is an employee of or has a written agreement with the hospice facility, to ensure that drugs and biologicals meet the patient's needs on a twenty-four hour basis.
1	Suggestion that "Availability of drugs and biological on a twenty-four- hour basis" line be deleted from Section 19a-122b-5 (a) (6) and that the need for availability of drugs and biologicals is addressed in Section 19a-122b-5 (d) (1)	Comment is taken into consideration, but no changes made.
1	"Pain assessment and management" might be moved from Section 19a-122b- 5 (a) (5) to Section 19a-122b-6(b)(8).	Comment taken into consideration, but no changes made. Pain assessment and management are the responsibility of the IDT and so it will remain under Section **19a-495-6e** General Requirements
3	Proposed regulation only requires an update to the existing assessment every 14 days regardless of the setting, and physician assessing within 48 hours of admission.	Preplanning the hospice admission allows the necessary history and physical examination to be completed in the community in a timely fashion. There are several sections of the regulations that address this comment as follows: Section **19a-495-6d** Administration (c) (1)(G) mandates

		the medical director to participate as a member of the interdisciplinary team in the development, implementation and assessment of patient centered plans of care. Section **19a-495-6e** General Requirements (d) (3) requires the licensee to have the assessment capability available on a twenty-four hour basis, seven days a week to respond to acute and urgent family needs. To address this further, the following sections of the regulations were revised: Subparagraph (J) was added to Section 19a-495-6d Administration (c)(1)(J) to mandate the Medical Director be available at all times. The language reads as follows: (J) The Medical Director shall be available for consultation 24 hours a day, 7 days a week and shall be on site at the hospice a sufficient number of hours to accomplish subsections (A) through (I) Section 19a-495-6e General Requirements (f)(1) mandates the facility to coordinate with the patient's physician and nurses prior to admission. The language reads as follows: The licensee shall assure the continuity of patient/family care through written policies, procedures and criteria including the following: (1) Coordination of community physicians and nurses with hospice staff prior to and at the time of admission; Section **19a-495-6j** Assessment and Patient Centered Plan of Care (a) mandates an initial assessment of the patient be completed at the time of admission. The new language reads as follows: (a) A licensed registered nurse shall complete a comprehensive assessment within 48 hours of a patient's admission to the hospice facility. The assessment shall evaluate the patient's immediate physical, psychosocial, emotional, and spiritual status. At the time of admission, a sufficient nursing initial assessment will be completed to meet the immediate needs of the patient
	Transfer or admission to hospice	See above revisions to section 19a-495-6e (f) (1) and

2	should be done in constant collaboration with the caregivers rather than with an emergency approach.	19a-495-6j(a)
1	Clarifications on the "completion of medical records" as the Medicare COPs do not prescribe a timeline for closing medical records.	To address this, Section 19a-495-6d Administration (i)(6) was revised to mandate the completion of the medical record within 30 days. This is consistent with other institutional licensing regulations. The new language reads as follows: (6) Completion of the patient's medical records shall be accomplished within thirty days after discharge or within thirty days of death. .
8	No mention at all in sections 19a-122b-1 to 19a-122b-14 that pastoral services must be available 24 hours; just that spiritual counseling services must be available and that the role of the spiritual counseling is oversimplified.	There are several sections of the proposed regulations that have requirements based on meeting the needs of the patients. To address this, section 19a-495-6f Hospice Services (b) (10) was revised to include a description of spiritual counseling services. This is consistent with other institutional regulations. The new language reads as follows: (10) Spiritual counseling services shall be provided in accordance with the wishes of the patient as noted in the patient centered plan of care. Services may include, but not be limited to: (A) Communication and support from local clergy or spiritual counselor; (B) Consultation and education for patient, family and interdisciplinary team members.
1	No mention at all in sections 19a-122b-1 to 19a-122b-14 that the director of volunteers shall be employed full time or that this individual is required to have 3 years of supervisory experience.	No changes made. Section 19a-495-6f Hospice Services (b) (12) addresses volunteer services. Section 19a-495-6g In-service Training and Education (1) mandates all volunteers to have an orientation program on the purpose, goals, mission and philosophy of hospice care and their specific duties. Though the qualifications for the Director of volunteer services are not specified, the qualifications of the volunteers that provide direct care are specified.
		No changes made. Section 19a-495-6e General Requirements (c)(6) addresses arts as part of the core

5	No mention at all in sections 19a-122b-1 to 19a-122b-14 that hospice shall provide arts to patients or families	services. It allows the licensee to provide many different complementary therapies. These therapies are not limited to arts or music, but also to other means of relaxation/entertainment like yoga, meditation, gardening, and Wii-console to accommodate and respect the ever-changing needs of the various age groups of patients.
7	No mention in sections 19a-122b-1 to 19a-122b-14 of the required years of practice for the individual directing social services.	No changes made. Under the Definitions section of the revised regulations, the social worker is to be licensed as a Licensed Clinical Social Worker pursuant to section 383b of the Connecticut General Statutes which is a higher credential than the Masters of Social Work required in current regulations. CGS section 20-195n calls for a LCSW to **1)** hold a doctorate or master's degree from a social work program accredited by the Council on Social Work Education, **2)** have 3000 hrs post-master's social work experience and **3)** pass the clinical level examination of the Association of Social Work Boards or any other examination prescribed by the Commissioner
1	Clarification on the role of the social worker providing social services.	To address this, section 19a-495-6f Hospice Services (b)(11) was revised to include a description of the social worker's functions, which is consistent with other institutional regulations. The new language reads as follows: (11) Social work services shall be provided as identified in the patient centered plan of care and in accordance with accepted standards of practice, applicable law and hospice facility policies. The social worker's functions shall include, but not be limited to: (A) Comprehensive evaluation of the psychosocial status of the patient and family as it relates to the patient's illness and environment; (B) Counseling of the patient, family and primary caregivers; (C) Participation in development of the patient centered plan of care; and, (D) Participation in ongoing case management with the hospice inter-disciplinary team.
2	The proposed regulations already require single rooms, and it is unnecessary to require a separate room for viewing a deceased	To address this, section 19a-495-6m Physical Plant (k)(7) was revised. Now language reads as follows: (7) For those patients who do not have a private room, a separate room will be made available for the viewing of a deceased patient's body until released to the

	patient's body. This requirement ignores the privacy and holistic bereavement of families.	responsible agent;
1	Proposed regulations are silent on compliance with NFPA 101, or the Life Safety Code design requirements.	No changes made. Section 19a-495-6m Physical Plant speaks of compliance with NFPA, State Building Code, and Fire codes
1	The term non-denominational "chapel" implies denomination which should not be intended	To address this, section 19a-495-6m Physical Plant (k)(6) was revised. New language reads as follows: (6) A comfortable space for spiritual purposes, which shall be appropriately equipped and furnished;
1	Prohibition of visitors from passing through the hospice unit space to another unit in the hospital should be clarified	Section 19a-495-6m Physical Plant (m) was revised to prohibit visitors from passing through the Hospice. New language reads as follows: (m) Access to the hospice facility shall be physically and operationally distinct from other patient care facilities that share the building space. The hospice facility shall prohibit visitors from passing through the hospice facility space to access another area of the building
1	Suggestion to replace the language "Licensee" with "IDT" in Section 19a-122b-10 (g) since the team is the intended manager of the plan of care.	Section 19a-495-6j Assessment and Patient Centered Plan of Care (g) was revised. New language reads as follows: (g) The interdisciplinary team shall ensure that the patient and family receive education and training provided by the hospice regarding the responsibilities of the patient or family for the care and services identified in the patient centered plan of care.
1	Clarification on the role of nursing director to avoid having hospice agencies use their home hospice supervisors in the inpatient settings.	Section 19a-495-6d Administration (d) was revised to create a full-time position for the Director of Nurses. New language reads as follows: (d) The licensee shall appoint a full-time director of nurses who is currently licensed as a registered nurse and possesses a baccalaureate degree in nursing with coursework or experience in hospice care; and,
1	Clarification on "In-service Training and Education" for all employees associated with providing hospice care.	Section 19a-495-6g In-service training and education (a)(1) and (2) were revised to include all employees. New language reads as follows: (a) An in-service educational program shall be conducted on a regular basis. Such program shall include but not be limited to: (1) An orientation program for new personnel, contracted staff that provide care to hospice facility patients, and volunteers, which shall address: (A) The purpose, goals, mission and philosophy of hospice care; and, (B) Each individual's specific duties.

		(2) Hospice focused in-service programs for all individuals providing care to hospice patients including employees, volunteers and contracted staff for the development and improvement of skills as identified by the quality assessment and performance improvement program;
1	Clarification on providing " short term respite care" under Section 19a-122b-13 Levels of Care	Section 19a-122b-13 Levels of Care was deleted from the regulation. The definition of "hospice facility" was revised to include short-term respite care under levels of care. New language reads as follows: (19) "Hospice facility" means a facility or hospice residence that provides palliative care for hospice patients requiring short-term, general inpatient care for pain and symptom management, end of life care or respite care;